

**OFFICE OF STATEWIDE HEALTH PLANNING AND DEVELOPMENT  
AMBULATORY SURGERY DATA RECORD  
MANUAL ABSTRACT REPORTING FORM**

Page 1 of 3

**Effective with encounters occurring on or after January 1, 2009**

Instructions: For a description of the data elements, refer to the appropriate section of the Patient Data Reporting Requirements  
(Title 22, Sections 97251 through 97265, and 97267)

<b>FACILITY ID NUMBER</b> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div>	<b>ABSTRACT RECORD NUMBER (Optional)</b> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div>		
<b>DATE OF BIRTH</b> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <p align="center"><i>Month   Day   Year (4-digit)</i></p>	<b>SEX</b> F Female M Male U Unknown  <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div>	<b>RACE</b> R1 American Indian or Alaska Native R2 Asian R3 Black or African American R4 Native Hawaiian or Other Pacific Islander R5 White R9 Other Race 99 Unknown  <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div>	<b>ETHNICITY</b> E1 Hispanic or Latino E2 Non-Hispanic or Non-Latino 99 Unknown  <div style="border: 1px solid black; width: 20px; height: 20px; margin: 0 auto;"></div>
<b>ZIP CODE</b> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div>	<b>PATIENT'S SOCIAL SECURITY NUMBER</b> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div>		
<b>SERVICE DATE</b> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <div style="border: 1px solid black; width: 100px; height: 15px; margin-bottom: 2px;"></div> <p align="center"><i>Month   Day   Year (4-digit)</i></p>			

**PRINCIPAL LANGUAGE SPOKEN**

Enter only one 3-digit value in the space provided.

Or, if patient's Principal Language Spoken is not included in the list, then enter language spoken, up to 24 alpha characters.

ENG English ARA Arabic ARM Armenian CHI Chinese FRE French CPF French Creole GER German GRE Greek GUJ Guarathi HEB Hebrew HIN Hindi HUN Hungarian ITA Italian JPN Japanese KOR Korean	LAO Laotian HMN Miao, Hmong KHM Mon-Khmer, Cambodian NAV Navajo PER Persian POL Polish POR Portuguese RUS Russian SCR Serbo-Croatian SPA Spanish TGL Tagalog THA Thai URD Urdu VIE Vietnamese YID Yiddish 999 Unknown
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**EXPECTED SOURCE OF PAYMENT**

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- |  |                                       |
|--|---------------------------------------|
| 09 Self Pay  | DS Disability                         |
| 11 Other Non-federal programs                          | HM Health Maintenance Organization    |
| 12 Preferred Provider Organization (PPO)               | MA Medicare Part A                    |
| 13 Point of Service (POS)                              | MB Medicare Part B                    |
| 14 Exclusive Provider Organization (EPO)               | MC Medicaid (Medi-Cal)                |
| 16 Health Maintenance Organization (HMO) Medicare Risk | OF Other Federal program              |
| AM Automobile Medical                                  | TV Title V                            |
| BL Blue Cross/Blue Shield                              | VA Veterans Affairs Plan              |
| CH CHAMPUS (TRICARE)                                   | WC Workers' Compensation Health Claim |
| CI Commercial Insurance Company                        | 00 Other                              |

**DISPOSITION OF PATIENT**

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- 01 Discharged to home or self care (routine discharge)
- 02 Discharged/transferred to a short term general hospital for inpatient care
- 03 Discharged/transferred to skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
- 04 Discharged/transferred to an intermediate care facility (ICF)
- 05 Discharged/transferred to another type of institution not defined elsewhere in this code list
- 06 Discharged/transferred to home under care of organized home health service organization in anticipation of covered skilled care
- 07 Left against medical advice or discontinued care
- 20 Expired
- 43 Discharged/transferred to a federal health care facility
- 50 Discharged home with hospice care
- 51 Discharged to a medical facility with hospice care
- 61 Discharged/transferred to a hospital-based Medicare approved swing bed
- 62 Discharged/transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital
- 63 Discharged/transferred to a Medicare certified long term care hospital (LTCH)
- 64 Discharged/transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare
- 65 Discharged/transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital
- 66 Discharged/transferred to a Critical Access Hospital (CAH)
- 00 Other

**PRINCIPAL DIAGNOSIS**

ICD-9-CM CODE

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**OTHER DIAGNOSES**

ICD-9-CM CODE

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**PRINCIPAL EXTERNAL CAUSE OF INJURY E-CODE**  
ICD-9-CM CODE

E					
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**OTHER EXTERNAL CAUSE OF INJURY E-CODES**  
ICD-9-CM CODE

a. 

E					
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b. 

E					
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c. 

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d. 

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**PRINCIPAL PROCEDURE**  
CPT-4 CODE

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**OTHER PROCEDURES**  
CPT-4 CODE

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